MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 18, 2001
10:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Assessing payment adequacy
Jack Ashby

MR. ASHBY: In this session we're going to lay out a proposal for revising the way that we update payments across all sectors in fee-for-service Medicare. We see problems, or maybe I should say at least three problems, in the process that we have been using to date.

First, we have tended to mix consideration of the adequacy of the current rates with the update needed for next year. At times that has caused considerable confusion.

Second, we have tended to focus on narrow issues, like how many tenths of a percent should be ascribed to the Y2K problem, or whether the cost of new technology is greater than expected productivity improvement, while at the same time devoting little attention to whether the current rate really is associated with efficient cost of care, which is an issue that could have far greater financial implications.

Then third, to the extent that we have considered payment adequacy, it has been in the form of attempting to measure individual factors that may have produced the imbalance. Things like unbundling, forecast error,
upcoding, and the like. Given the difficulty of measuring those individual items, it seems like it might be better to focus on the outcome which is, is today's base rate the right one, regardless of how we got where we are.

As an example of the problem, the issue we're dealing with, the Medicare margin for inpatient services over the last decade has ranged from minus two to 17. That is a huge range. The industry representatives have tended to stress that payments have gone down since the BBA relative to cost, and they have. But that implies that the peak point as of 1997 is the right one, and no one ever said that, or at least no one from Congress or the Medicare program ever said that.

For our part, we have tried to fill out the picture a little bit showing that that decline was preceded by an even larger increase. But again, that might be construed as implying that the trough point, which was 1992, was the right one. Again, no one really ever said that. The unanswered question the whole time is, what is the appropriate level of payment? That's the question that we really would like to focus on.

Many have suggested that the task of deciding how money ought to be in the system is practically an impossible one. That may be true, but we would like us all to remember that Congress and CMS implicitly make decisions about the appropriate amount of money in the system quite frequently. CMS decides the overall level of payments ever time it launches a new PPS. It usually sets aggregate payments equal to current aggregate costs, but not always. Recently in starting the SNF PPS, for example, they set the initial payment rate below current cost.

Congress make payment adequacy decisions. A couple of examples are the 15 percent cut in home health payments that is

still looming in front of us, contemporary 4 percent increase in SNF payments. In fact one could take the stance that there is an implicit payment adequacy decision involved in every update that is promulgated.

So the point here is that if explicit decisions are not made, then implicit ones will be. Our thinking is that perhaps the Commission's judgments could help Congress in making those final payment level decisions.

With that premise in mind, we are proposing today a model where the annual updating process would routinely be divided into two steps, a two-step process. As we see in this first overhead, the first step would be assessing the adequacy of the current base rate, which would hopefully result in a stated conclusion about whether payments are about right, too high, or too low, and then a recommendation for adjusting that base payment rate as applicable.

Then the second part of the process would be determining an adjustment that accounts only for factors expected to affect provider's costs in the coming year. Then the final update as depicted in the figure here simply combines the two percentage changes.

In the remainder of my presentation I'm going to focus on the first part of this process, the basic payment adequacy. Then Nancy Ray will be back once again to take on the second part of this process. What I'm going to do is review three generic steps in the payment adequacy assessment process, take a look at several factors that might be considered in assessing payment adequacy, and then discuss several related issues, we might call them complications, that may arise in the process.

So let's go on to the next overhead. This depicts the basic process. The three steps involved are very straightforward conceptually. The first step measuring current Medicare payments and cost is nothing more than documenting where we are at the beginning of the process; how much money is in the system. I would point out though that in the case of physicians we don't have any measurement of cost. All we can do is measure the amount of payments. It doesn't take away from the model. It's equally applicable. But we have the constraint that we don't have cost data to deal with, so we have to go as best we can with that process.

Then the second step is determining where we want to be, how much money should be in the system. And the third step is devising some sort of an approach for getting to where we want to be. Now I have a couple of comments about the first and third steps a little later, but right now we want to focus on the middle step, which is indeed where the action is.

One of the important things to understand about assessing payment adequacy is that it's actually a two-step process, connoted by the two bullets in that middle box. We would be looking, hopefully separately, at the appropriateness of current costs, and then at the relationship of payments to cost. A couple of examples I think is maybe the best way to appreciate the difference between these two looks.

When ProPAC and MedPAC several years ago called for a series

of negative adjustments to inpatient payments for unbundling following this massive decline in length of stay, while we never said this explicitly, I think it's fair to say that the Commission didn't really have any quarrel with current costs. The problem was that payments were too high relative to those costs.

But when CMS a couple of years ago set the initial base payment rate in the SNF PPS below current cost, it conversely was really saying that they thought costs were too high and they were looking to establish an incentive for providers to bring down those costs. We wouldn't want that to be interpreted as they thought payments ought to be less than costs and someone else has to subsidize it. They were really looking for costs to be brought down.

So our suggestion in laying this out as a two-part process is just simply that we think that our deliberations will go more smoothly, and our conclusions might be more readily understood by the policy world if we make it clear which of these two issues we're focusing in on, or both, sequentially.

Now the box on the lower left that we have labeled market condition factors, these are potential clues that we have available to us as to whether the current cost base is appropriate or payments are appropriate relative to those costs. First, of course, is the recent cost growth. Of course, recent doesn't have to be a couple of years. It depends on the dynamics. We can go back five and 10 years if we want to. And the third one, pressure from private payers, both of these are getting at the appropriateness of current costs.

The second bullet there, evidence of unbundling, would suggest that payments are too high, as we said. While on the other hand, evidence of access problems, to the extent we can measure that directly, would point to payments being too low. We like to point out that it's rather hard to detect payments being too high with access measures, but it can give you clues that payments are too low.

Then the last two as examples, the supply of providers willing to accept Medicare patients and the volume of care, these tend to work in both directions. If we saw a large drop in willing providers or in the volume of service, it might indeed be a suggestion that payments are too low relative to cost. The converse is true, too. If we saw a massive influx of new providers and a huge volume increase, might be a suggestion that the rates are really a bit too attractive.

Conspicuous in its absence from this list of market factors is the margin. We've had some considerable discussion about this in the office, but the way we're looking at this is that given that the current costs imbedded in that margin may or may not be the appropriate cost, then the margin in and of itself doesn't tell you anything about where we ought to be. It tells you where we are now. It really does not, in and of itself, answer the question of where we think we ought to be. So the margin is basically in step one of this process.

Then the factor off to the right in the lower right box there is an entirely separate consideration. If we thought that

current costs did represent efficient costs, as best as we can determine, then we have a separate decision to make: where should we set the payments relative to those costs? Should they be equal? Should they be 4 percent above? Whatever. This is basically trying to ask the question what our standard margin should be, or perhaps more appropriately, a standard range of margin.

But the efficient modifier is critically important here, because without it we could be setting ourselves up for the scenario where the standard margin becomes a floor, and any time we have large cost increases and we dip below the standard margin it's time for a pay increase. That's what we don't want to do.

I think ProPAC was implicitly saying that for eyars back in the late '80s -- this discussion went on year after year -- they observed that the inpatient margins had gone down from well above zero to well below zero. They basically concluded that this was due to an unreasonable rate of cost growth and that we were not going to respond with higher updates. So while I'm not even sure we even used the term efficient costs, this is the process that was basically going on.

The Commission will have to decide whether it wants to weigh in on what this standard margin ought to be relative to efficient cost. Our limited contact with experts and literature search has suggested that certainly there is no right number here for an entire industry. It's a function of the risk providers take, and that's something that we could debate around the clock. It's a judgmental matter. I guess we're just suggesting that the fact that it is judgmental is not necessarily reason to shy away from it. As we were saying before, the decisions are going to get made one way or the other. The question is whether we have something to say about it.

If we can move on to the next overhead, this is the first of several related issues that will come into play. I sort of stacked the difficult ones up front here and the easier ones later so don't get discouraged if this looks difficult. This is indeed one of the difficult questions. We would suggest the matter of multi-product providers, we would suggest that perhaps the most practical way to assess payment adequacy is to look at the combination of all Medicare services that a certain type of organization provides.

One problem with trying to do it separately by each service is that there is indeed cost shifting among services. This is certainly the case with hospitals. There have been past incentives for hospitals to load costs into outpatient, SNF, and home health, which were then cost-based payment. Probably the only way that we've ever going to get an accurate picture of payments and the associated cost is by combining them together. I doubt that we're ever going to be able to accurately measure the degree of that cost shifting, although there have been a couple of attempts to do that. So that seems to lead to the conclusion we ought to wrap it all together.

A separate problem of sorts is that the payment rates for different services an organization provides may be at vastly different levels. That seems to be generally the case with

dialysis centers. I think it's well known that the payment rates on the drugs used are way higher relative to cost than facility-based payments. So again, it's really only by looking at the two together that you get any kind of a picture of the revenue constraints that a dialysis center faces in providing services.

Now while this is, we think, the best approach, all factors considered, we do have to acknowledge that it makes the process more difficult. If we do decide that payments are too high or too low, then you have a follow-up decision: where among these services are you going to institute some change? We may need to make adjustments in more than one service, and you have to balance that out to get back to the whole.

Next issue, also not an easy one, is factors outside of Medicare. Certainly our general operating premise is that we try to relate payments to the cost of treating Medicare patients. One could consider non-Medicare revenue streams in developing the update, and in fact we did so once, many of you will remember, two years ago in our inpatient update.

But what we more wanted to talk about today was the disproportionate share and the indirect medical education adjustments. Both of these payment components in the inpatient sector are intended to compensate for what one could call non-Medicare factors. We believe that they are the only components in the entire Medicare fee-for-service that do so. The disproportionate share basically compensates for inadequate payment for indigent care programs and no payment from uncompensated care.

Over on the IME side, part of the IME adjustment is indeed to pay for the added costs associated teaching, but part of it goes beyond that. It basically appears to respond to low total margins resulting from uncompensated care again, and the effects of above average cost due to their teaching research missions, and the like, in the private sector.

Our premise here is that for purposes of assessing the adequacy of Medicare payments relative to the cost of treating Medicare patients, it would seem that payments that don't relate to cost of Medicare patients are basically outside the scope of the analysis.

So we are proposing that when we return in December and actually try our hand at assessing payment adequacy for hospital inpatient-outpatient services, that we base the assessment on Medicare payments and cost for all Medicare services that hospitals provide, as we talked about a moment ago, but with the payments recalculated to exclude DSH payments and the above-cost portion of the IME. We then end up with a margin that is useful for analytical purposes but does not really represent the actual revenue stream. We've separated out the non-Medicare related payments.

The third issue is considering the distribution of payments in all of this. If we were to determine that payments are too high or too low but the problem is concentrated on some subset of providers, then an adjustment to the update that would affect all providers is probably not the right remedy.

An example of this is the expanded transfer policy that was

instituted several years ago for inpatient payments. Congress very explicitly intended this payment adjustment to reduce aggregate payments. But they also intended the reductions to be targeted to a specific group of hospitals, mainly those that had benefited the most in the past from unbundling. Often though, the situation as we come into the picture is reversed. Policymakers don't set out to look at the aggregate level of payment. They set out to address a distributional issue.

But in this situation we would still think it's a good idea to consider whether the overall amount of money in the system is about right before deciding whether some distributional change should be done budget neutral or involving new money or savings.

A current example of this, a recent example, was the increase in payments that Congress enacted for rural home health agencies. They set out to help that specific subset of home health agencies, but presumably they concluded that the overall amount of money in the system was too small and went ahead and approved new money. I guess we're mainly just saying that that latter decision should not be made lightly. It's something that we ought to look at as we're considering various distributional issues.

The fourth issue is pretty straightforward conceptually. That is that due to reporting lags, our data don't always reflect the impact of all current policies. So we don't really have current payments and current costs to deal with. We try to compensate for this by modeling the effects of new payment policies, and that seems to be the right thing to do. But we have to point out that where a policy is likely to have behavioral responses, such as is almost always the case when you institute a new PPS, the modeling is really rather difficult. In fact it's essentially impossible, and we're stuck with data that are certainly less than what we would like to be dealing with.

The next issue, this really relates back to earlier discussion of payment adequacy. That is the potential role of alternative measures of financial performance. It was suggested in our earlier discussion that perhaps a return on equity measure might be more useful than margin in this kind of assessment.

But after looking into this, first of all we're not sure that a return on equity measure is really appropriate for non-profit providers. But even more problematical than that is the fact that there's no meaningful way to make this measure specific to Medicare. The same could be said for various cash flow measures. They may inform in the process, but you can't really measure the adequacy of Medicare payments with that tool.

So the bottom line is that neither of these approaches we think replaces the need for measuring Medicare payments and cost, which generally are best expressed with a margin.

Then the last issue, that I was only going to touch on lightly today, is the issue of Medicare's non-allowable costs. In the past when Medicare generally paid on the basis of reasonable cost, I think there was a little dispute among policymakers anywhere that we need to have some limits on the cost that Medicare would pay for. But as we approach the point where all payments are prospective, the future of this non-

allowable cost concept, perhaps for today we'll just say it's something that needs to be carefully thought out.

My only point in bringing it up today is first to acknowledge that it is a relevant consideration in assessing payment adequacy. You're always trying to assess payments relative to cost, and this is a question, what are costs? But also to let everyone know that we are going to do a study in this area. Basically it's the first ever study to attempt to estimate how much difference non-allowable costs make, and to find out what the actual composition of these costs. What cost elements are we talking about that really drive the amounts of money?

This turns out to be a far more difficult analytical exercise than one might think. It's going to take us a while to do it, and the results will not be available for this year's deliberations on payment adequacy. But several months from now we hope to have some interesting information and then we'll all sit back and try to figure out what to do with it for our future deliberations.

So that's basically the model. Questions?

DR. NEWHOUSE: First of all, Jack, I have no problem with trying to disentangle the adequacy from the update. We've talked about that before and there's even, I think, precedent for that conceptually going all the way back to the beginning of PPS, since people talked about re-basing versus updating way back when.

I had, I guess, three kinds of comments I wanted to make. One is, I don't think, with kind of one exception I'll come to at the end, that we should focus that much attention on the margin. The first reason is that basically the product can adjust here. This is not a perfectly defined product. As hospitals came under price pressure in recent years, we reduced nurse staffing. That clearly affected their margin. If they hadn't done that, they'd have had a more negative margin presumably.

Another way to say that is when you use the language, cost of an efficient provider, which I agree has a kind of hallowed usage around here, that's conditional on some product. It's efficiency at producing that product. So we've always slid by that ambiguity and never really reached the kind of product. But we could have rates cut to a point where we would turn the hospital industry into People's Express, and I'm not sure we should want to do that. But I think this is all a way of saying that the margin doesn't really tell us anything about whether we have a desirable product that we're buying or not.

The second point is actually an extension of your multiple payer point. To the degree that the private market in a locality has price competition -- and I think that's true of probably most big cities, and therefore most hospitals since there's where most hospitals are -- if Medicare changes its rates we are likely to see an offset on the private side in the other direction. Another way to say this is, this is what we used to call cost shifting. But basically Medicare announces what it is going to pay, the hospital still has costs to cover if it doesn't cut out costs, and it goes back to private payers and say, we're going to have to charge you more this year.

Now that's says in the long run hospitals are going toward some kind of margin. But the margin is determined by then the degree of competition in the local market, not by what Medicare is paying. Indeed, in most industries we think margins are determined by the degree of competition. If you have a monopoly, you can get a higher margin. So that's one point.

The one exception to this where I think we should pay attention is to changes in margin as we're measuring them where we think we have a story to tell. So I think that's the unbundling case. We saw hospitals length of stay falling, we saw the use of post-acute care facilities, many of which hospitals owned or operated, rising a lot, we saw margins going up. This all added up to a story to tell, and I thought that was a perfectly legitimate use of the margin. So that's really as distinguished from saying, we're regularly aiming at 5 percent. That's one set of comments.

The second comment is the view that we should look at what at other times and places you've called the most-of-Medicare margin. That is to say, we should add together all the units of the hospital, which I'm sympathetic to. The problem with it is, which you don't really get to here, is different hospitals have different mixes of services. I don't know how you propose to handle that in comparing subgroups. So if we want to compare rural hospitals -- actually we just had an illustration of that with the cancer hospitals, and how much outpatient they had or didn't have.

The idea is if we want to compare across our groups, probably the proportion of revenue that's coming from SNF and home health and rehab, and so forth and so on, is going to vary across those groups. It surely varies between rural and major teaching.

So I'm not sure how to handle that beyond trying to control for that in some statistical fashion. I don't know if you were contemplating doing that or not. That doesn't seem to me so straightforward to do.

The third point I wanted to make is, to the degree we are going to use margins -- and as I say, in the unbundling case I thought they were quite helpful in telling a story about what was going on -- I think we need the cost report, which we're going to come to tomorrow when we talk about regulatory complexity. So somehow what's going on in this part of our report has to meet up with our regulatory complexity report.

MR. ASHBY: I'd like to comment on just a couple of those points. The first one, don't focus too much attention on margins. We absolutely agree and tried to make that point, it's not really one of the factors that one uses. That may have been less clear in the paper that you were reading, but we in fact want --

DR. NEWHOUSE: I thought there were some even more fundamental reasons not to do it than what you had here, and we should make some of those points.

MR. ASHBY: I want to make -- sort of the second part of that statement though, and that is that I guess in trying to mull this over it does seem to me though that inevitably you do reach

a point where you conclude, this is the cost base we want to pay for and you can't escape the question of whether you want the payments to be less and we're looking for subsidies from other payers, or you want to be at the same, or you want it to be X percent higher or whatever. I don't know how you escape that question. It seems like one that just has to be answered before you can get to the finish line.

DR. NEWHOUSE: I guess I would just say, I don't think it can be. If I take Jack back to his prior life when he was CEO of Mount Sinai, how I allocated the portion of his salary to Medicare and to private payers is quite arbitrary. But that's going to affect what I choose to call the Medicare margin and the private payer margin. So how those numbers come out is really an accounting convention. The ultimate story is if those costs are going to be covered, they have to be covered somewhere. That in fact probably accounts for quite a bit of what we see in the variation when Medicare changes rates.

MR. ASHBY: It does. That will eventually be a point that we will stress in this discussion of non-allowable costs. It's really the allocation that drives the stuff.

But I guess it just seems to me we end up with a vicious circle. You can't really do it, but you can't not do it either, because let's face it, you're still studying payments in the end.

DR. NEWHOUSE: First of all, I would distinguish level of margin and changes in margin, because I think as long as you're doing it consistently at least, maybe the changes tell something.

Then second is, I think there's no escaping from -- you think there's no escaping from the margins. I think there's no escaping from looking at what you're actually buying. You have to say something about what the product is. Are the hospitals producing the care you want to produce, or are they too starved for funds, or are they very flush and they're building great palatial buildings or what?

But as I say, because the margin -- I can reduce my margin by putting in very fancy facilities, having a lot of debt service. Medicare may or may not want to pay for that. But then to come back and say, my margin is low; give me money, that doesn't make much sense to me.

DR. ROSS: Joe, can I give a slightly different characterization here? Because you could look back historically and say that in fact a lot of decisions were based looking solely at margins, and perhaps even at the margins. Instead what we're trying to suggest is, when we're dealing in the world of financial performance, let's try and get a better measure, or at least erase some of the biases that we think are in there. For example, the inpatient-outpatient cost allocation issue.

But second is to be more explicit about recognizing the limitations of any given measure of financial performance and look to the other pieces that we have. This came up last year in the context of dialysis facilities where you could look at the margin on the PPS side of payments, or you could look at all of the payments. Then you'd take that piece of information and put it together with the extremely rapid infusion of new providers and you could start to draw some conclusions, which the

Commission did.

So it's not that we're even deluding ourselves in trying to craft the perfect margin. We're trying to get a better measure of financial performance, but also to bring in more of the other pieces that we know about.

DR. NEWHOUSE: As I said, I agree with bringing in the other pieces. The issue was how to do that and still make comparisons among hospitals that had different product mixes.

DR. REISCHAUER: Joe really touched on this. I think conceptually you're headed in the right direction. But then I ask myself, practically, what's going to come out the other end?

MR. ASHBY: Yes, we worry about that, too.

DR. REISCHAUER: I think you're right to do this on an institutional or entity basis, but as Joe points out, the hospital will have inpatient, outpatient, SNF, maybe hospice, maybe home health. Just take one hospital and if I did these calculations and I found that payments were insufficient, how would I know which particular ones were? I have a sample of 4,000 hospitals and I do a regression of these that has these services as variables, but then I can think of 4,000 other variables that I'd have to include in that equation before I'd be comfortable with the coefficients.

DR. ROSS: Is there an alternative?

DR. REISCHAUER: No, it's just that we know where the limitations of the existing system are and we're going to do one which I think is a lot more defensible, might it not come up with answers. As I said before, go to it.

DR. WAKEFIELD: Jack, just three quick questions. I'm referring now to the document that we had a chance to take a look at in advance of the meeting. I liked the notion of your taking a long term look at non-allowable costs. I think that will be very informative at least. I thought it was kind of interesting though your casting of it in the text, and maybe it is the truth, the Commission most likely will not want to address its Medicare margins to add back non-allowables. That may well be the case. But I also thought, maybe depending on what you learn two years from now there's going to be something done with some piece of that. So it's only a cautionary note to say, I'm not sure we want to put --

MR. ASHBY: There's a future debate on that. I guess I was mostly saying, we can't really resolve that right now, especially in advance of doing the study. But there was absolutely a future discussion about whether this concept has any future.

DR. WAKEFIELD: Right, or some part of it, might get adjusted or whatever. So I just think there was a little bit of a bias that might have been introduced in that text that I don't know if you intended.

MR. ASHBY: I will work on that because I do not intend to introduce that bias. I think it's an open question, and a little down the line the Commission may want to get involved in that as well.

DR. WAKEFIELD: I think it will be very helpful to have that kind of information later on.

The other comment that I had on this document that we

received in advance was your discussion about base payment rates and looking further at varying the base rates when there are differences in broad groups of providers, when those differences in broad groups of providers would seem to warrant differences or variation in base rate. I've got a question, and if I knew the answer I wouldn't be asking you this, so please don't interrupt it as being too off the wall.

But I was wondering if it's worth giving some thought to being really sure that the differences between those groups aren't due to characteristics that could be modifiers of a uniform base rate, rather than the establishment of separate base rates. Is that another way of looking at this?

MR. ASHBY: Yes, absolutely. In fact that's one classical way to look at PPS design, is that you always ought to spin off of one rate, and if there are the need for adjustment factors for this and that that are different among groups you do it with adjustments.

DR. WAKEFIELD: So we may have that sort of a notion entertained in here somewhere too then?

MR. ASHBY: Yes, we should probably play that out a little bit more.

DR. WAKEFIELD: Thank you.

MR. HACKBARTH: Any other comments?

I guess I'm with Bob on this. He put it far better than I would be able to. It all makes sense to me. I don't have a Ph.D. in economics but it seems logical to me what you propose, Jack. I'm very uncertain about exactly where it leads and what it's going to feel like when we do it. When I look at the list of market condition factors, some of those are readily measurable and familiar things that we've looked at before. Others are, I think going to be much more difficult to get a grip on.

MR. ASHBY: Right. It's going to inevitably be a rather judgmental process, so we tried to make that clear. It's just inevitable.

MR. HACKBARTH: But having said that, that's certainly a problem with our current framework is that we end up talking about imponderables and making guesses at them, usually offsetting guesses.

MR. ASHBY: Yes, exactly. The way I like to look at it is, we either have a broad imponderable or we have two or three narrow imponderables, but either way you end up making educated guesses. So that the added imprecision of going down to narrow variables does not appear to be really solving the problem.

MR. HACKBARTH: So I guess hearing no other comments, we have at least the general feeling that this is a direction that we ought to be moving, although be it with a little trepidation, at least on my part.

DR. ROSS: Think about it in conjunction with the next session.

MR. HACKBARTH: Yes. Why don't we just go ahead and move on to the next session?

MS. BURKE: One question. I was looking back through this, and tell me whether or not I just missed this or whether it's not part of the formulation. That is in looking at the adequacy of

the rates as well as the updates, are you also going to examine the relationship between different service aspects of the problem? So that it's not only the question of the adequacy of the rate for hospitals, but whether or not if you look across the array of services that Medicare provides, how those payments are distributed?

MR. ASHBY: You mean like inpatient to outpatient, or outpatient to physician?

MS. BURKE: I mean whether or not as you look at the totality of what we spend, the adequacy of the individual rates, whether or not the distribution among services makes sense.

MR. ASHBY: I think we were anticipating mostly concentrating on the distribution among services provided by the single organization. Once you go across organizations it just raises another level of complexity. But it's certainly there.

MR. HACKBARTH: Let me raise one other question, and maybe it's rhetorical in nature. For all of the flaws of our current framework, there is some familiarity to it, and similar thinking has been used by other people to try to wrestle with the appropriate update. We would be going off in a somewhat different ground, maybe a better ground, but it will raise a communication challenge for us. Reading this material, it was hard for me to come to grips with, and now we're talking about going to a much larger, more diverse audience with a change in our thinking. Not necessarily a reason not to do it but --

DR. NEWHOUSE: Glenn, I didn't think it was that big a change. I thought this was kind of codifying where we had come to over the last few years.

MR. ASHBY: Right. And I can visualize a situation too where the end product is a very simple, two numbers summed to a third number, and it will be a little easier to absorb than the framework we've had with lots of details in it previously.

MR. HACKBARTH: Your point is well taken, Joe. It may be just because you're a lot smarter than I am, but when I sit down to read this, it was a struggle for me to wrestle with it and what the implications of this might be. I didn't as quickly make the connections as you. So just something to be --

MR. ASHBY: We have struggled with it too, and we work with it every day. In fact we continued to struggle with it after we sent the paper to you and ended up making additional changes. It's not easy concepts.

MR. HACKBARTH: Let's move on to the update piece of this.